North Dakota Department of Human Services
Affiliations

Click here for a Sample Affiliation Form.

Link to Affiliation Form SFN 1330: https://www.nd.gov/eforms/Doc/sfn01330.pdf

In order to bill on a 1500 claim form, the billing group (clinic, practice, etc.) and the individual rendering provider must be enrolled. Also, the rendering provider must be linked ("affiliated") to the billing provider in the system.

Affiliations can be requested during the group enrollment (if the individual provider is already enrolled with ND Medicaid) or during the individual rendering provider's enrollment (if the group is already enrolled with ND Medicaid. To request during enrollment, add the provider's 7 digit Medicaid ID# to the "Affiliation" section of the online application. If you do not know the Medicaid ID, you may enter the NPI of the provider you wish to affiliate. Please Note: When adding a group affiliation to an individual application, if you input the group's NPI, staff may pull up more than 1 record. If this happens, and both records would allow the affiliation, staff will contact you to request additional information.

If you need to add an affiliation, and both the group and the individual are already enrolled with ND Medicaid, submit an affiliation form (SFN 1330) along with a copy of the provider's license and DEA (if applicable). The license and DEA must go back to the effective date requested on the form. You may submit copies of multiple licenses and DEAs if needed.

Effective Dates:
A retroactive enrollment effective date is limited to no more than ninety (90) days* prior to the date a complete affiliation request is received.

*The PIU may consider a retro effective date that exceeds ninety days for situations involving emergent care provided to a ND Medicaid member. To request a retro effective date that exceeds ninety days, providers must include a copy of the claim and medical records with their affiliation documents.

When a provider is no longer providing services, submit a Termination Form (SFN 1331). See the section titled "Termination" for more information.

1. Submit Affiliation Form: SFN 1330
    a. Individual Provider's Information goes in the top section
    b. Billing Provider's (Group) Information goes in the middle section (the "Affiliate To" section)
    c. Name, Email, and Phone Number of the person submitting the affiliation form goes in the bottom section. This information is used to send a confirmation email after the affiliation is processed.
2. Submit license/s that cover the requested effective date on your SFN 1330 to present
3. Submit DEAs (if provider has a DEA) that cover the requested effective date on your SFN 1330 to present
4. Submit list of all service locations where the practitioner will be the providing services for the billing provider listed on the form

Submit To:

1. Regular Email: NDMedicaidEnrollment@noridian.com
2. Fax: 701-433-5956, ATT: NDM Provider Enrollment.

Created 1/2/2018
Revised 4/29/2021

REQUEST TO ADD AN AFFILIATION

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION/ PROVIDER ENROLLMENT
SFN 1330 (10-2018)

The Department will not gran[t] than one year from the date of receipt. Credentialing staff must ensure the effective date is c[orrect] ffiliation paperwork. Any [change] ange the date will not be considered.

Name of Individual Practitioner being Affiliated

Date the Form is submitted to the Department

Name of Provider	Date	
NPI — NPI of Individual being Affiliated	Health Enterprise Number — 7 Digit Medicaid ID of the Individual Practitioner being Affiliated	
Service Location Ad[dress] — Address where the Individual is providing services. if more than one service location, please submit a list of all service locations.	City	State / ZIP Code
Is this the primary s[ervice location]? ☐ Yes ☐ No	Requested Effective Date — The Department will not grant an effective date that is more than 90 days from the date the affiliation request (correct and complete with all attachments) is received.	

Please submit a list of all service location addresses being added for this individual at the time of this request a[ffiliation].
These service locations must already be added to the Medicaid provider number of the billing provider listed be[low].

AFFILIATE TO

Name of Billing Group (Facility billing for the practitioner's services)

Billing Provider Name	Billing Provider Health Enterprise Number — 7 Digit Medicaid ID of Billing Group (Facility) REQUIRED	
Billing Address — Billing and Mailing Addresses of the Billing Group	City	[State] / ZIP Code
Mailing Address	City	State / ZIP Code

Please submit the following documentation with this request:

1. Copy of current license. North Dakota Medicaid requires providers to be licensed in the state where the provider is rendering services.
2. Copy of current DEA license (if applicable).

If these items are not received, your affiliation request is **not complete**

Submit by fax, email or mail to:

Fax: Providers may fax the required documentation and this form to 701-328-4030.

Email: dhsenrollment@nd.gov

Mailing Address:

Provider Enrollment
Medical Services
North Dakota Department of Human Services
600 E Boulevard Ave. Dept. 325
Bismarck, ND 58505-0250

Name, Phone, and Email are all Required Fields

CONTACT INFORMATION FOR REQUESTOR

Name, phone, and email of person filling out this form - usually credentialing staff.

Name	Telephone Number
Email Address	